



FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARY C. BOYLE		2a. DATE OF DEATH MONTH DAY YEAR 4-13-81		2b. HOUR 9:50 PM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Aug. 1 1909	
6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		7. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		10. CITY OR TOWN OF DEATH Leonardtwn		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Nursing Home	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a STATE Md.		12b. COUNTY St. Marys		12c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13a. STREET ADDRESS P. O. Box 418		13b. CITY OR TOWN Leonardtwn		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harvey Blair Engle		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Mae Clawson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -	
17. SOCIAL SECURITY NO 172-03-0466A		18. INFORMANT Vernon B. Boyle		19. ADDRESS 11293-Laurel Walk Dr., Laurel, Md.	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of the Breast 1749 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
22a. DATE OF OPERATION		22b. CONDITION FOR WHICH OPERATION WAS PERFORMED		22c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		22f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
22g. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22i. LOCATION CITY OR TOWN COUNTY STATE	
22j. I certify that (I) (this hospital) attended the deceased from 5-30-79 , 19____, to 4/13/81 , 19____, that (I) (we) lost saw the deceased alive on 4/13/81 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22k. SIGNATURE Wm. H. Tanner		22l. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22m. DATE SIGNED 4/13/81	
22n. PHYSICIAN'S NAME (TYPE OR PRINT)		22o. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/17/1981		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.		23e. DATE REC'D. BY REGISTRAR APR 20 1981		23f. REGISTRAR'S SIGNATURE Jeffrey M. [Signature]	
24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc.		24b. ADDRESS Mt. Rainier, Md.			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 2 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ROGER A. DARR							7a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 4 5 1981		7b. HOUR M		
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR MARCH 13 1922		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 59		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 5 1981	
7d. HOUR 3p		7e. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County					
10. CITY OR TOWN OF DEATH Charlotte Hall		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) (auto) Rt. 5				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY CONTRACTING			
13a. STATE VA.		13b. CITY OR TOWN Fairfax Falls Church		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 2209 WEST MORELAND ST.					
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM E. DARR				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAE JOHNSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT VITALIS DARR		17. ADDRESS BARTON, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive & arteriosclerotic cardiovascular disease 4029 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER DATE SIGNED 4-6-81			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE APRIL 8, 1981		23c. NAME OF CEMETERY OR CREMATORY LAUREL HILL CEMETERY				23d. LOCATION CITY OR TOWN COUNTY STATE MOSCOW MILLS ALLEGANY MD.			
24. FUNERAL DIRECTOR NAME BOAL'S FUNERAL SERVICE, P.A.				25a. DATE REC'D. BY REGISTRAR APR 10 1981		25b. REGISTRAR'S SIGNATURE 					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

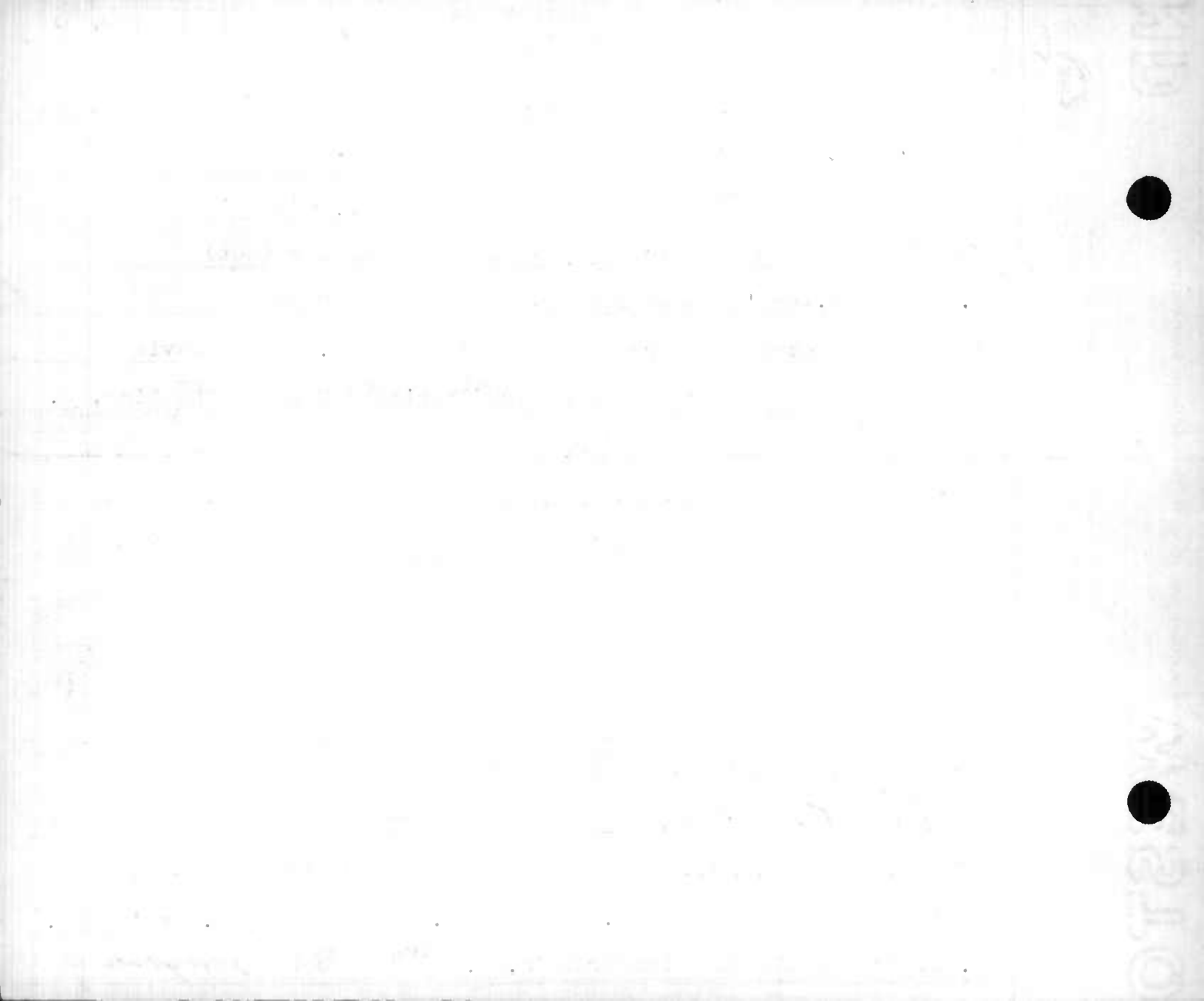
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ruth Farr Drury			2a. DATE OF DEATH MONTH 4 DAY 6 YEAR 81			2b. HOUR 6:10 A.M.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 12 DAY 05 YEAR 06		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 		8. IF UNDER 24 HRS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maddox		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.					
10. CITY OR TOWN OF DEATH Chaptico		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home, Chaptico, P.O. Box 86				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cashier (Ret)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY St. Mary's		13c. CITY OR TOWN Chaptico		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Box 86		
14. FATHER'S NAME FIRST Joseph MIDDLE Jackson LAST Farr				15. MOTHER'S MAIDEN NAME FIRST Sarah MIDDLE P. LAST Davis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217 32 4364 A			17. INFORMANT ADDRESS Francis B. Gough Box 86 Mary Charlotte Evans Chaptico, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Liver Failure									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks		
1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									DUE TO, OR AS A CONSEQUENCE OF (b) Hepatic Metastases 4 months		
									DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of pancreas 6+ months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (1) (this hospital) attended the deceased from 10 February , 19 81 , to 6 April , 19 81 , that (1) (we) last saw the deceased alive on 5 April 81 , 19 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (1) (we) did not view the body after death, so state.)											
22a. SIGNATURE John W. Roache						DEGREE M.D., F.A.C.S.			22c. DATE SIGNED 6 April 1981		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) John W. Roache, M.D., F.A.C.S.						22e. ADDRESS Box 186, Mechanicsville, Maryland 20659					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/8/81		23c. NAME OF CEMETERY OR CREMATORY St. Joseph Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Morganza St. Mary's Md.			
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley						ADDRESS Leonardtown, Md.			25. DATE REC'D. BY REGISTRAR APR 9 1981		
						25b. REGISTRAR'S SIGNATURE Jeffrey Hubbard					

BP.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11346		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charles Nathaniel Fauth										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR ESTIMATED <input type="checkbox"/> Apr. 21, 1981		2b. HOUR 1240 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 28, 1919	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 61	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD April 21, 1981		2d. HOUR 1240 M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St Mary's MD.						
10. CITY OR TOWN OF DEATH Mechanicsville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) at home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE Maryland		13b. COUNTY St Mary's,		13c. CITY OR TOWN Mechanicsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 774 Scott Circle, Golden Beach				
14. FATHER'S NAME FIRST MIDDLE LAST Puis C. Fauth				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie Portner								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) Air Force		16b. SOCIAL SECURITY NO. 168 14 1878		17. INFORMANT Emily East Fauth		ADDRESS same as # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9530 ASPHYXIATION BY HANGING DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1030 P.M. 4-21 1981		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) HANGED SELF								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 774 SCOTT CIRCLE MECHANICSVILLE ST. MARY'S MD.								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <i>William D. Boyd</i>				TITLE (SPECIFY) DEPUTY		M.D.		DATE SIGNED 4/22/81				
EXAMINER'S NAME (TYPE OR PRINT) William D. Boyd, M.D.				ADDRESS Leonardtwn, Maryland								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE April 22, 1981		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G., Maryland						
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley				ADDRESS Leonardtwn, Maryland		25a. DATE REC'D. BY REGISTRAR APR 24 1981		25b. REGISTRAR'S SIGNATURE <i>William D. Boyd</i>				



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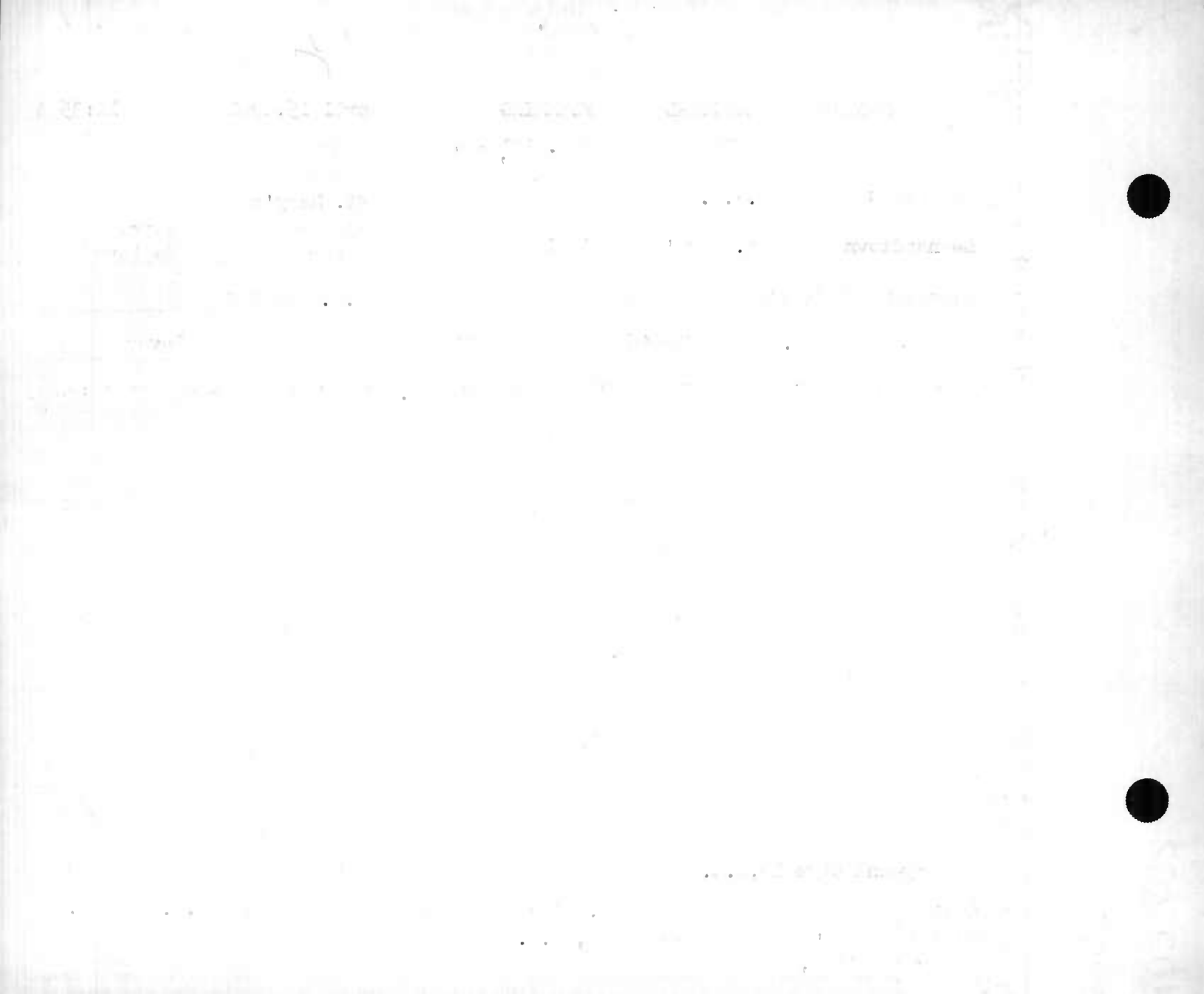
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MED EXAMINER NOTIFIED

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 1 1 1 3 4 7	
1. FOR STATE REGISTRAR					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) GEORGE MICHAEL FLEMMING			2a. DATE OF DEATH MONTH DAY YEAR April 15, 1981		2b. HOUR 11:35 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JAN. 13, 1915		
6. AGE (IN YEARS LAST BIRTHDAY) 66		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		8. IF UNDER 1 YEAR MONTHS DAYS YRS		
9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's		10. CITY OR TOWN OF DEATH Leonardtown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital		
12. USUAL OCCUPATION (IF NOT WORK FOR MOST OF WORKING LIFE) Owner		13. KIND OF BUSINESS OR INDUSTRY Employed		14. FATHER'S NAME FIRST MIDDLE LAST John B. Flemming		
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jenny Glover		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577 16 1638		
17. INFORMANT ADDRESS Mrs Betty W. Flemming Same as #13 (Wife)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) none						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 4/15 19 81 to 4/15 19 81 , that (I) (we) lost saw the deceased alive on 4/15 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Raymond Bayerle		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/15/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raymond Bayerle, M.D.		22e. ADDRESS ST. MARY'S Hosp. LEONARDTOWN, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/18/81		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.		24. FUNERAL HOME OR OTHER PLACE WHERE FUNERAL SERVICES WILL BE HELD NAME ADDRESS Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland		25a. DATE REC'D. BY REGISTRAR APR 20 1981		
25b. REGISTRAR'S SIGNATURE Robert McCready						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 3 4 8			
FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
GEORGE ALEXANDER FREEMAN JR.				APRIL 25 1981 0800A M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
MALE		CAUCASIAN		AUG 21 1923		57 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. COMMON LAW WIFE MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
WEST VIRGINIA		USA				ST. MARY'S MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
DAMERON		St. Jerome's Neck Rd., Dameron, Md		U.S.N. RETIRED		MILITARY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS?			
13a. STATE MARYLAND 13b. COUNTY ST. MARY'S 13c. CITY OR TOWN DAMERON				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
HECK FREEMAN SR.				ST. JEROME'S NECK ROAD DAMERON, MD.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO		17 INFORMANT ADDRESS	
YES				410-30-8112		ST. JEROME'S NECK RD. DAMERON, MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROBABLE CARDIO PULMONARY ARREST 4149 DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21e. LOCATION STREET CITY OR TOWN COUNTY STATE					
21f. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
22a. I certify that (I) (this hospital) attended the deceased from July 19 80, to April 19 81, that (I) (✓) lost saw the deceased alive on April 19 81, and that in (my) (or) opinion death occurred on the date and hour and from the causes stated above. (I) (✓) (did) (did not) view the body after death.							
22b. SIGNATURE Robert Harris MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 25 APRIL 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert HARRIS M.D.				22e. ADDRESS NAVAL HOSPITAL, PATUXENT RIVER, MD. 20670			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		April 28, 1981		Happy Valley Memorial		Elizabethton, Tennessee	
24 FUNERAL DIRECTOR NAME ADDRESS W. Clarke Mattingley Leonardtown, Maryland				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
				APR 28 1981		[Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) MIGNONETTE MARGARET GATTON					2a. DATE OF DEATH April 21, 1981			2b. HOUR 11:00A_M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept. 21, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.					
10. CITY OR TOWN OF DEATH Leonardtwn		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY St. Mary's		13c. CITY OR TOWN Dameron		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Ernest L. Robinson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Mae Ridgell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 214-72-4827		17. INFORMANT Dicky Gatton			ADDRESS Leonardtwn, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Acute Myocardial Infarction (c) Heart APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from 19 65 to 4-21 19 81 , that (1) was last saw the deceased alive on 4-21 19 81 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (1) was (did) not view the body after death.											
22b. SIGNATURE J. Patrick Jarboe, M.D.					22c. DATE SIGNED 4/27/81			22d. ADDRESS Leonardtwn, Maryland 20650			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 4-24-81		23c. NAME OF CEMETERY OR CREMATORY St. Michael's		23d. LOCATION CITY OR TOWN COUNTY STATE Ridge St. Mary's Md.		
24. FUNERAL DIRECTOR NAME Brinsfield Funeral Home					ADDRESS Leonardtwn, Maryland		25a. DATE REC'D. BY REGISTRAR MAY 4 1981		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

THE NEW YORK PUBLIC LIBRARY

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U. S. DEPARTMENT OF AGRICULTURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 1 3 5 0	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) CLYDE IGNATIUS GOLDSBOROUGH			2a. DATE OF DEATH April 1, 1981		2b. HOUR 01:15 AM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR January 10, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 86	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.	
10. CITY OR TOWN OF DEATH Leonardtwn	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saw Mill Operator	12b. KIND OF BUSINESS OR INDUSTRY Lumber	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. CITY OR TOWN St. Mary's 13c. CITY OR TOWN Leonardtwn			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS General Delivery Box 143	
14. FATHER'S NAME FIRST MIDDLE LAST George H. Goldsborough			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Brown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-14-7198	17. INFORMANT ADDRESS Vanetta C. Goldsborough Leonardtown, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Failure DUE TO, OR AS A CONSEQUENCE OF (c) Sepsis; Reported 10/2/81 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/31/81 to 4/1/81 , that (I) do do not saw the deceased alive on 3/31/81 19 81 , and that in (my) own own opinion death occurred on the date and hour and from the causes stated above. (If well well did not view the body after death)					
22b. SIGNATURE J. Patrick Jarboe, M.D.		DEGREE M.D.		22c. DATE SIGNED 4/2/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Patrick Jarboe, M.D.		22e. ADDRESS Leonardtwn, Maryland 20650			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-4-81	23c. NAME OF CEMETERY OR CREMATORY Our Lady's		23d. LOCATION CITY OR TOWN COUNTY STATE Leonardtwn, St. Mary's Md.
24. FUNERAL DIRECTOR NAME Brinsfield Funeral Home ADDRESS Leonardtwn, Md.			25a. DATE REC'D. BY REGISTRAR APR 9 1981 25b. REGISTRAR'S SIGNATURE Anthony McCreedy		

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April 1, 1911

April 1, 1911

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April 1, 1911

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April 1, 1911

April 1, 1911

April 1, 1911

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THOMAS YATES GOLDSBOROUGH			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR APR 4 19 81			2b. HOUR 3:03 A M		
3. SEX MALE	4. RACE CAUC	5. DATE OF BIRTH MONTH DAY YEAR OCT 2 1911	6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR APR 4 19 81	2d. HOUR 3:03 A M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LEONARDTOWN		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S MD		
10. CITY OR TOWN OF DEATH PATUXENT RIVER		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVHOSP PATUXENT RIVER MD			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN		12b. KIND OF BUSINESS BROOKFIELD UNIFORM CO.	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. CITY OR TOWN ST. MARY'S		13c. CITY OR TOWN LEXINGTON PARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST J Frank Goldsborough			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Victoria Florence Yates					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 578-09-7999		17. INFORMANT ADDRESS 94 DANA COURT LEXINGTON PARK, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMED.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>William D. Boyd Sr.</i>			TITLE (SPECIFY) DEPUTY		MEDICAL EXAMINER		DATE SIGNED 4-6-81	
EXAMINER'S NAME (TYPE OR PRINT) William D. Boyd Sr., M.D.			ADDRESS Leonardtwn, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/7/81		23c. NAME OF CEMETERY OR CREMATORY Our Ladys Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Medleys Neck St. Mary's Md.		
24. FUNERAL DIRECTOR NAME ADDRESS W. Clarke Mattingley Leonardtown, Maryland				25a. DATE REC'D. BY REGISTRAR APR 28 1981		25b. REGISTRAR'S SIGNATURE <i>Robert M. Brady</i>		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



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U.S. DEPARTMENT OF JUSTICE

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

10

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DATE 11-11-01 BY 60322 UCBAW/STP

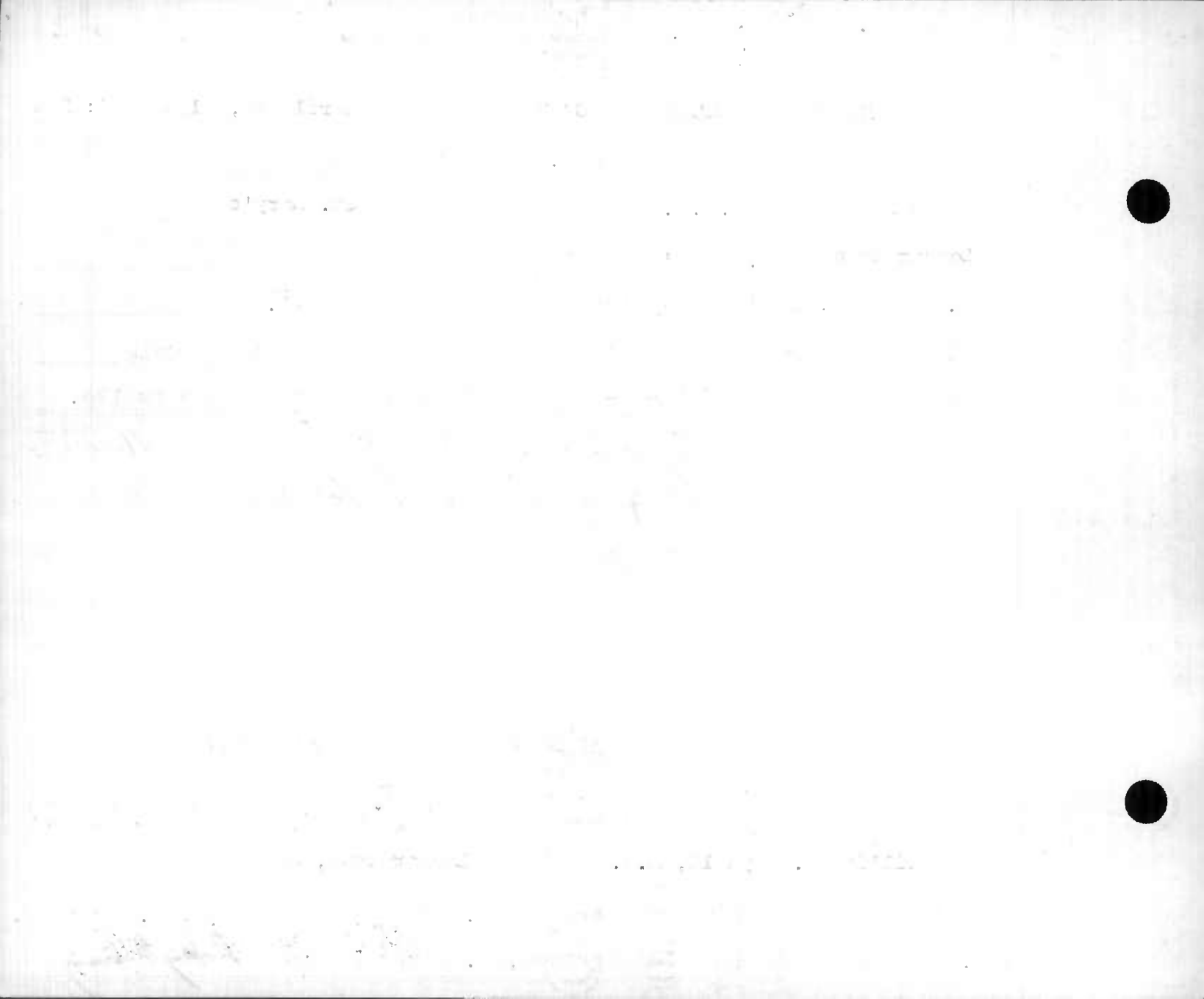
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8111352	
1- FOR STATE REGISTRAR		REG. NO.									
1 DECEASED NAME (TYPE OR PRINT) NANCY ELLEN GRAY					2a. DATE OF DEATH MONTH DAY YEAR April 24, 1981			2b. HOUR 5:25 A			
3. SEX Female		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Aug. 10 1916		6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Chaptico		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.					
10 CITY OR TOWN OF DEATH Leonardtown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. St. Mary's Chaptico					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Gen Del.				
14. FATHER'S NAME FIRST MIDDLE LAST Olie Edward Curtis					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Cecelia Cole						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-30-0457B		17. INFORMANT ADDRESS Julious Paul Gray Same as 13e.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 Hours</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/23/81</u> , 19____, to <u>4/24/81</u> , 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>William D. Boyd II</u>						DEGREE			22c. DATE SIGNED <u>4/24/81</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William D. Boyd II, M.D.						22e. ADDRESS Leonardtown, Md			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/27/81		23c. NAME OF CEMETERY OR CREMATORY Charles Mem. Gardens			23d. LOCATION CITY OR TOWN COUNTY STATE Leonardtown, St. Mary's Md.			
24 FUNERAL DIRECTOR NAME W. Clarke Mattingley						ADDRESS Leonardtown, Md.			25a. DATE REC'D. BY REGISTRAR APR 28 1981		
									25b. REGISTRAR'S SIGNATURE <u>William D. Boyd II</u>		

BP



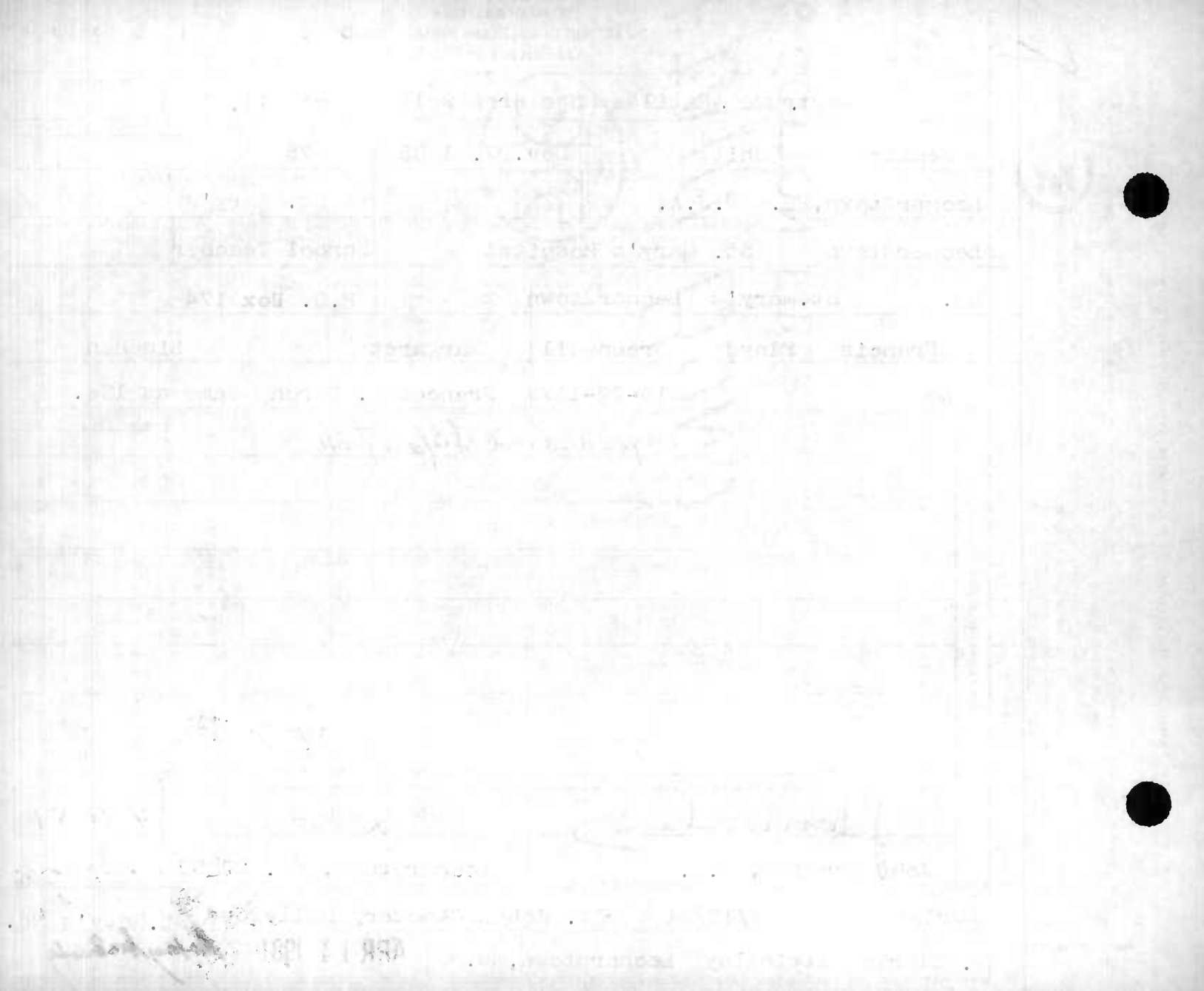
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 17224 after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Gertrude Matilda Hope Greenwell					2a. DATE OF DEATH MONTH DAY YEAR April 11, 1981			2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 7, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Leonardtwn, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.			
10. CITY OR TOWN OF DEATH Leonardtwn		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.					13b. COUNTY St. Mary's		13c. CITY OR TOWN Leonardtwn		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Francis Floyd Greenwell					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Linehan				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 216-22-1379		17. INFORMANT ADDRESS Frances G. Burch Same as 13e.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>John Fenwick</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4.12.81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Fenwick, M.D.					22e. ADDRESS Leonardtwn, Md. 20650				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/13/81		23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery Hollywood		23d. LOCATION CITY OR TOWN COUNTY STATE St. Mary's Md.		
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley					ADDRESS Leonardtwn, Md.		25a. DATE REC'D. BY REGISTRAR APR 14 1981		

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

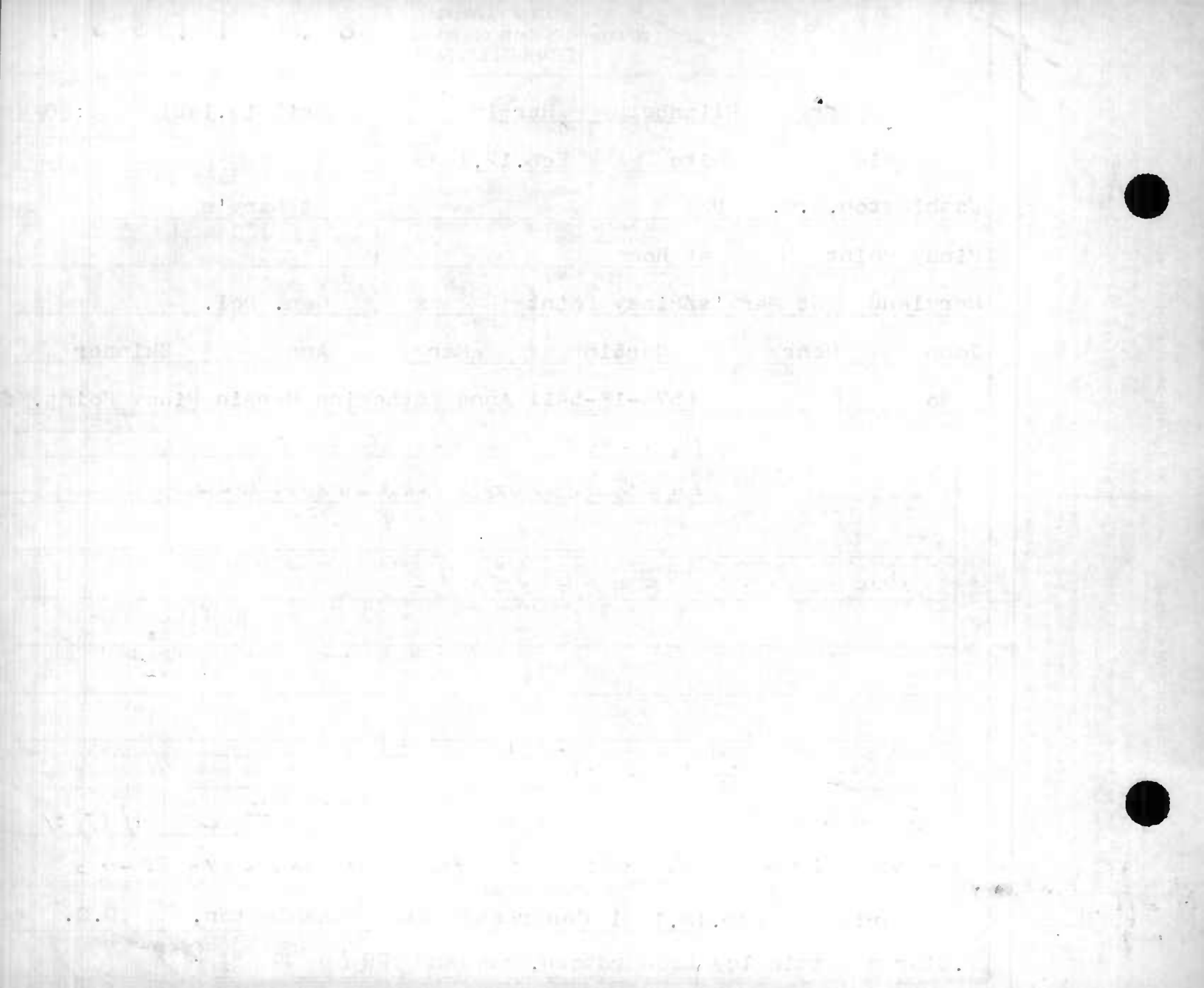
1. DECEASED NAME (TYPE OR PRINT) Mary Elizabeth Harbin			2a. DATE OF DEATH MONTH DAY YEAR April 15, 1981			2b. HOUR 3:30AM				
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 12, 1899		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH St Mary's MD.				
10. CITY OR TOWN OF DEATH Piney Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) at home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY St Mary's		13c. CITY OR TOWN Piney Point		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Gen. Del.	
14. FATHER'S NAME FIRST MIDDLE LAST John Henry Harbin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ann Skinner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-18-5411		17 INFORMANT ADDRESS Anna Katherine Harbin Piney Point, Md						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PROBABLE CARDIAC EVENT 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) PULMONARY EMPHYSEMA										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 4/14 , 19 81 , to 4/15 , 19 81 , that (I) (we) lost saw the deceased alive on 4/14 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE Annie Jean DiDonato				DEGREE M.D. EMERGENCY ROOM ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/17/81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANNIE JEAN DiDONATO				22e. ADDRESS Box 405; DAHLGREN, VA. 22448						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 18, 1981		23c. NAME OF CEMETERY OR CREMATORY Congressional		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.				
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley Leonardtown, Maryland				ADDRESS APR 20 1981		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE [Signature]				

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

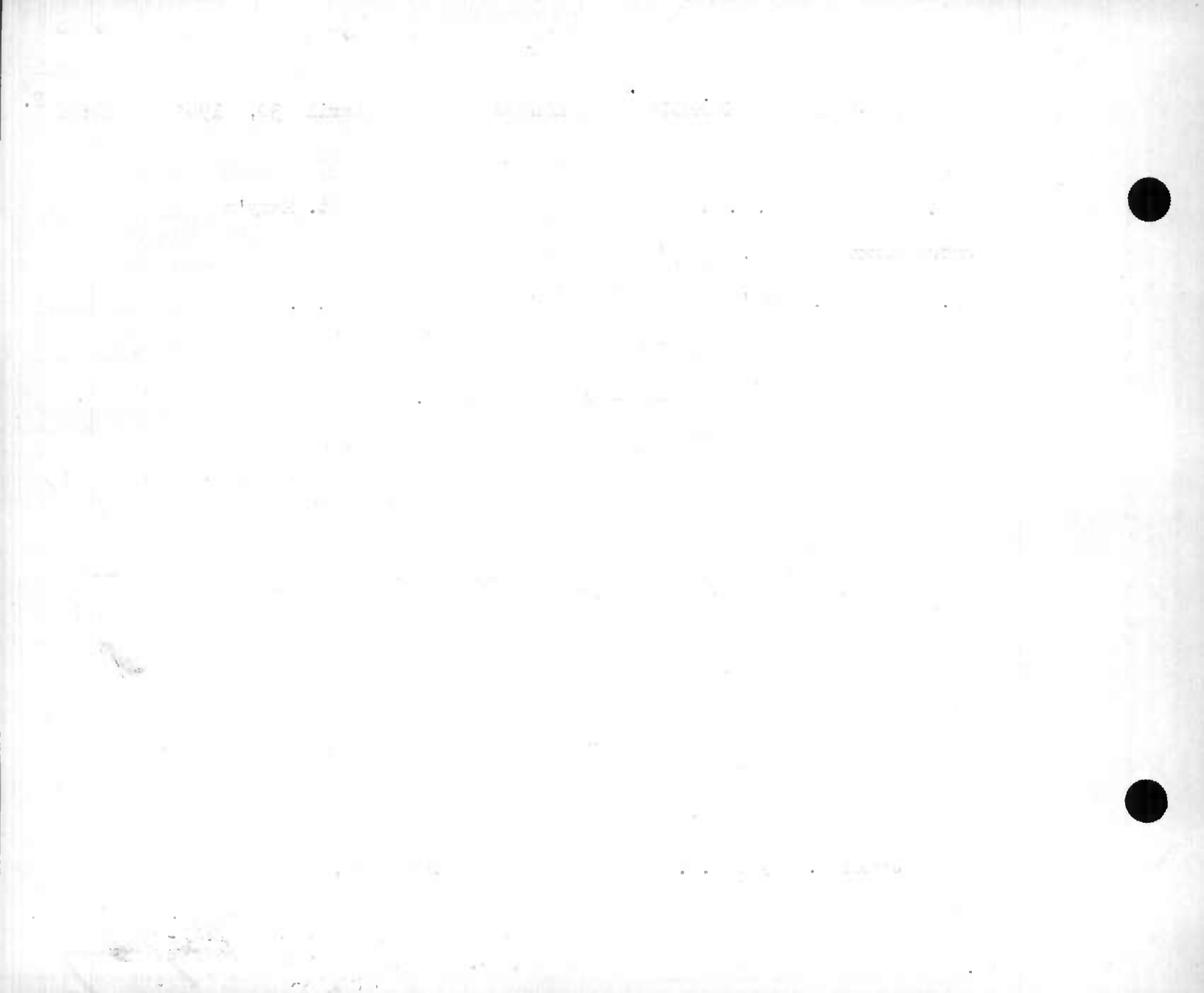
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8111355	
FOR 1- STATE REGISTRAR				REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) JOHN FRANCIS HOLTON				2a. DATE OF DEATH MONTH DAY YEAR April 30, 1981				2b. HOUR 10:06 P.			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR April 8, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.					
12. CITY OR TOWN OF DEATH Leonardtwn		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. CITY OR TOWN St. Mary's Mechanicsville 13c. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				17. STREET ADDRESS P.O. 244							
18. FATHER'S NAME FIRST MIDDLE LAST Frederick Holton				19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Barnes							
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		21. SOCIAL SECURITY NO 214-18-8115A		22. INFORMANT ADDRESS Essie M. Holton Same as 13c.							
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic alcohol abuse + Severe Cachexia 4255 DUE TO, OR AS A CONSEQUENCE OF (b) with Cardiomyopathy + cirrhosis + renal failure DUE TO, OR AS A CONSEQUENCE OF (c) failure											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Hypoglycemia, Hypothermia, Disseminated intra vascular coagulation											
24. DATE OF OPERATION 4/28		25. CONDITION FOR WHICH OPERATION WAS PERFORMED				26. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
31. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		33. LOCATION CITY OR TOWN COUNTY STATE Leonardtwn, Md							
34. I certify that (I) (this hospital) attended the deceased from 4/22 , 19 81 , to 4/30 , 19 81 , that (I) (we) last saw the deceased alive on 4/28 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
35. SIGNATURE James G. Boyd, M.D.				36. DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				37. DATE SIGNED			
38. PHYSICIAN'S NAME (TYPE OR PRINT) James G. Boyd, M.D.				39. ADDRESS Leonardtwn, Md							
40. BURIAL, CREMATION, REMOVAL Burial		41. DATE 5/4/81		42. NAME OF CEMETERY OR CREMATORY Charles Memorial		43. LOCATION CITY OR TOWN COUNTY STATE Leonardtwn St. Mary's Md.					
44. FUNERAL DIRECTOR NAME W. Clarke Mattingley				45. ADDRESS Leonardtwn, Md.		46. DATE REC'D. BY REGISTRAR MAY 6 - 1981		47. REGISTRAR'S SIGNATURE Robert H. H. H.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 1 3 5 6			
1- REGISTRAR				CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Dorothy Ann Johnson				2a. DATE OF DEATH MONTH DAY YEAR April 26, 1981				2b. HOUR M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 23, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Medley's Neck, Md.		10. CITIZEN OF WHAT COUNTRY? USA		11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH St Mary's MD.					
13. CITY OR TOWN OF DEATH Mechanicsville		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) at Home				15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker		16. KIND OF BUSINESS OR INDUSTRY			
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE Maryland				17b. COUNTY Sr Mary's		17c. CITY OR TOWN Mechanicsville		17d. STREET ADDRESS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
18. FATHER'S NAME FIRST MIDDLE LAST James C. Faunce				19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Madge Raley							
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		21. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		22. INFORMANT ADDRESS George T. Johnson Mechanicsville, Md.							
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Leiomyo sarcosis ovary</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED				26. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
31. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		33. LOCATION STREET CITY OR TOWN COUNTY STATE							
34. I certify that (I) (this hospital) attended the deceased from <u>1955</u> , 19 <u>81</u> , to <u>26 Apr</u> , 19 <u>81</u> , the (I) (we) lost saw the deceased alive on <u>Apr 20</u> , 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
35. SIGNATURE <u>Leon Berube</u> MD.				36. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				37. DATE SIGNED			
38. PHYSICIAN'S NAME (TYPE OR PRINT) Leon Berube, M.D.				39. ADDRESS Mechanicsville, Md. 20659							
40. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		41. DATE Apr. 29, 1981		42. NAME OF CEMETERY OR CREMATORY Queen of Peace		43. LOCATION CITY OR TOWN COUNTY STATE Helen, St Mary's, Maryland					
44. FUNERAL DIRECTOR NAME W. Clarke Mattingley Leonardtown, Maryland				45. ADDRESS		46. DATE REC'D. BY REGISTRAR APR 29 1981		47. REGISTRAR'S SIGNATURE <u>History</u>			

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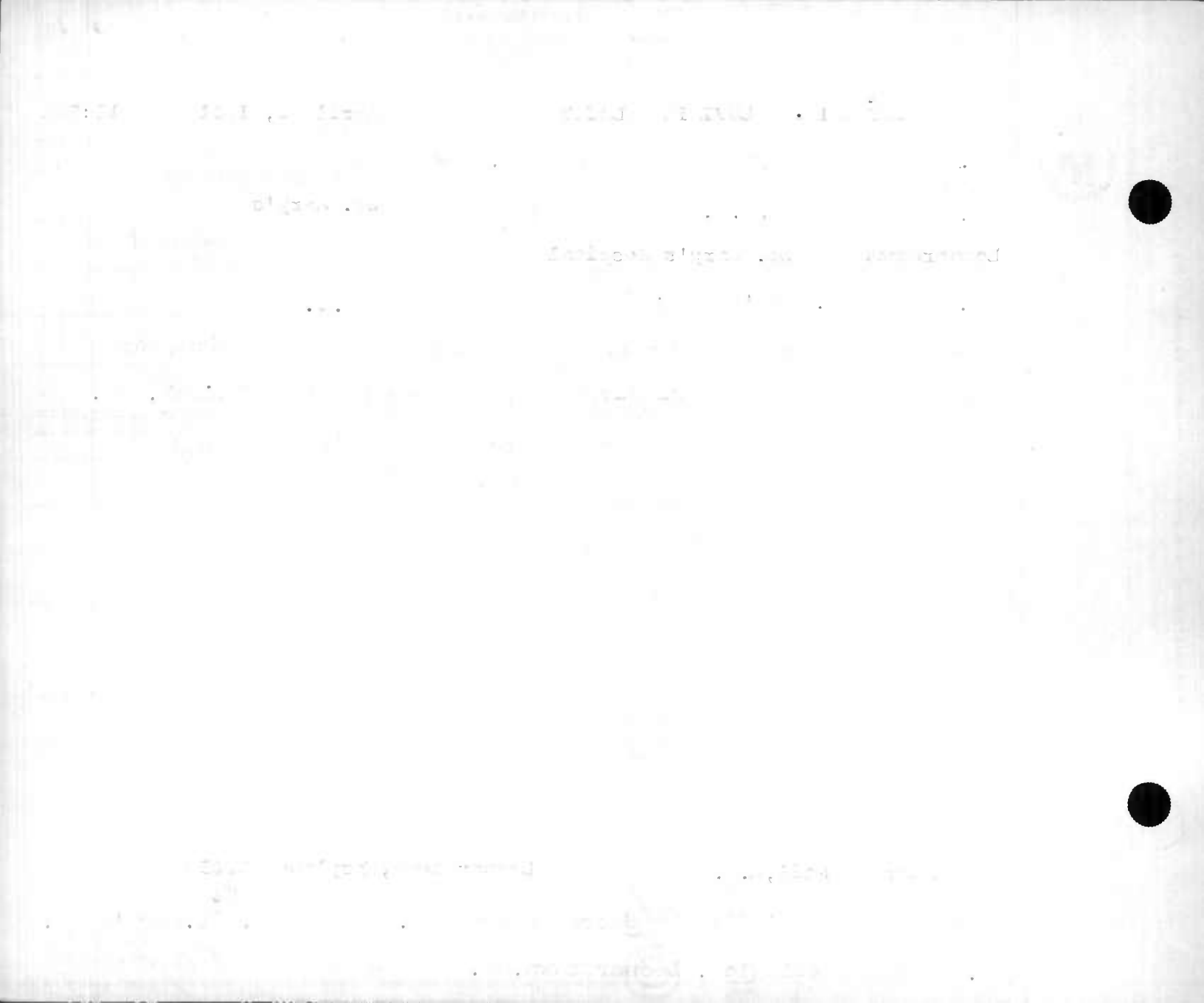
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TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8111357	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) CATHERINE LUVINIA LACEY					2a. DATE OF DEATH MONTH DAY YEAR April 6, 1981			2b. HOUR 11:50AM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR July 29, 1904		6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.					
10. CITY OR TOWN OF DEATH Leonardtwn		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.					13b. COUNTY St. Mary's		13c. CITY OR TOWN Maddox		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Frank Thomas					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Thompson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-34-7019		17. INFORMANT James Elmer Lacey			ADDRESS Rt. 238 Maddox, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Adinath Patil					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Adinath Patil, M.D.					22e. ADDRESS Leonardtwn, Maryland 20650						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/8/81		23c. NAME OF CEMETERY OR CREMATORY Sacred reart Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Bushwood, St. Mary's Md.				
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley, Leonardtown, Md.					25a. DATE REC'D. BY REGISTRAR APR 08 1981		25b. REGISTRAR'S SIGNATURE Robert M. Brady				



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

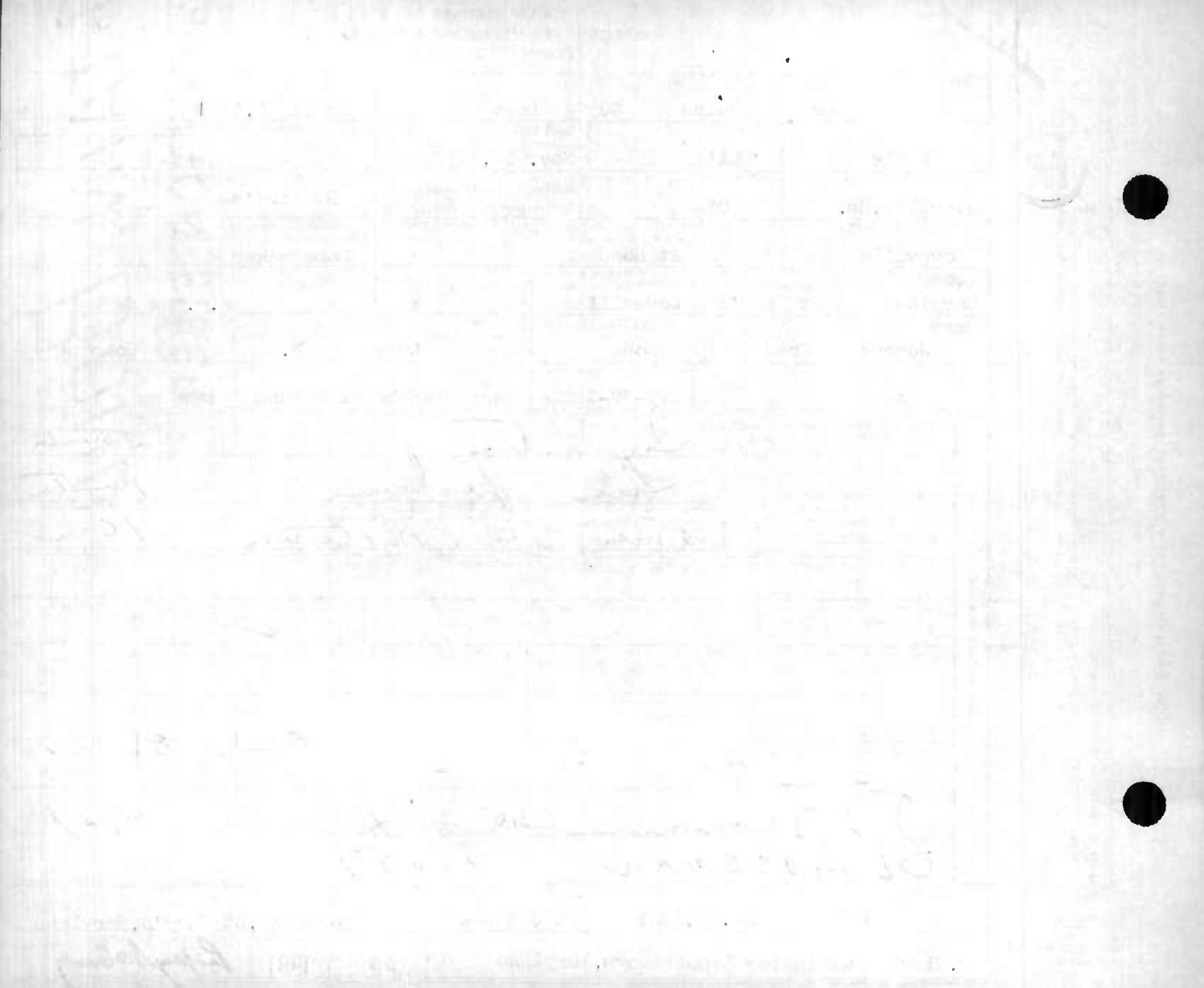
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mary Louise Guy Love		2a. DATE OF DEATH MONTH DAY YEAR April 25, 1981		2b. HOUR M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Nov. 14, 1910	
6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Loveville, Md.		6b. CITIZEN OF WHAT COUNTRY? USA		6c. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	
7a. CITY OR TOWN OF DEATH Loveville		7b. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At home		7c. BALTIMORE CITY OR COUNTY OF DEATH St Mary's MD.	
8. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY St Mary's		13c. CITY OR TOWN Loveville	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Fred Long		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy M. Johnson		16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		17b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-32-3862A		17c. INFORMANT ADDRESS Mary Blanche Pilkerton same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line, and in full) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suppression</u> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Liver failure</u> (c) <u>Cancer, Colon & Metastasis</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>1 month</u> <u>16 months</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 81</u> , 19 <u>57</u> , to <u>April</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>4/25</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>DL Mossman</u>				22c. DATE SIGNED <u>4/27</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DL MOSSMAN</u>				22e. ADDRESS <u>20657</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 28, 1981		23c. NAME OF CEMETERY OR CREMATORY St Josephs	
23d. LOCATION CITY OR TOWN COUNTY STATE Morganza, St Mary's, Maryland		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE <u>L. J. K. Brady</u>	
24. FUNERAL DIRECTOR NAME ADDRESS W. Clarke Mattingley Leonardtown, Maryland		25. DATE REC'D. BY REGISTRAR APR 29 1981			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

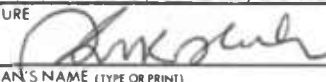

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

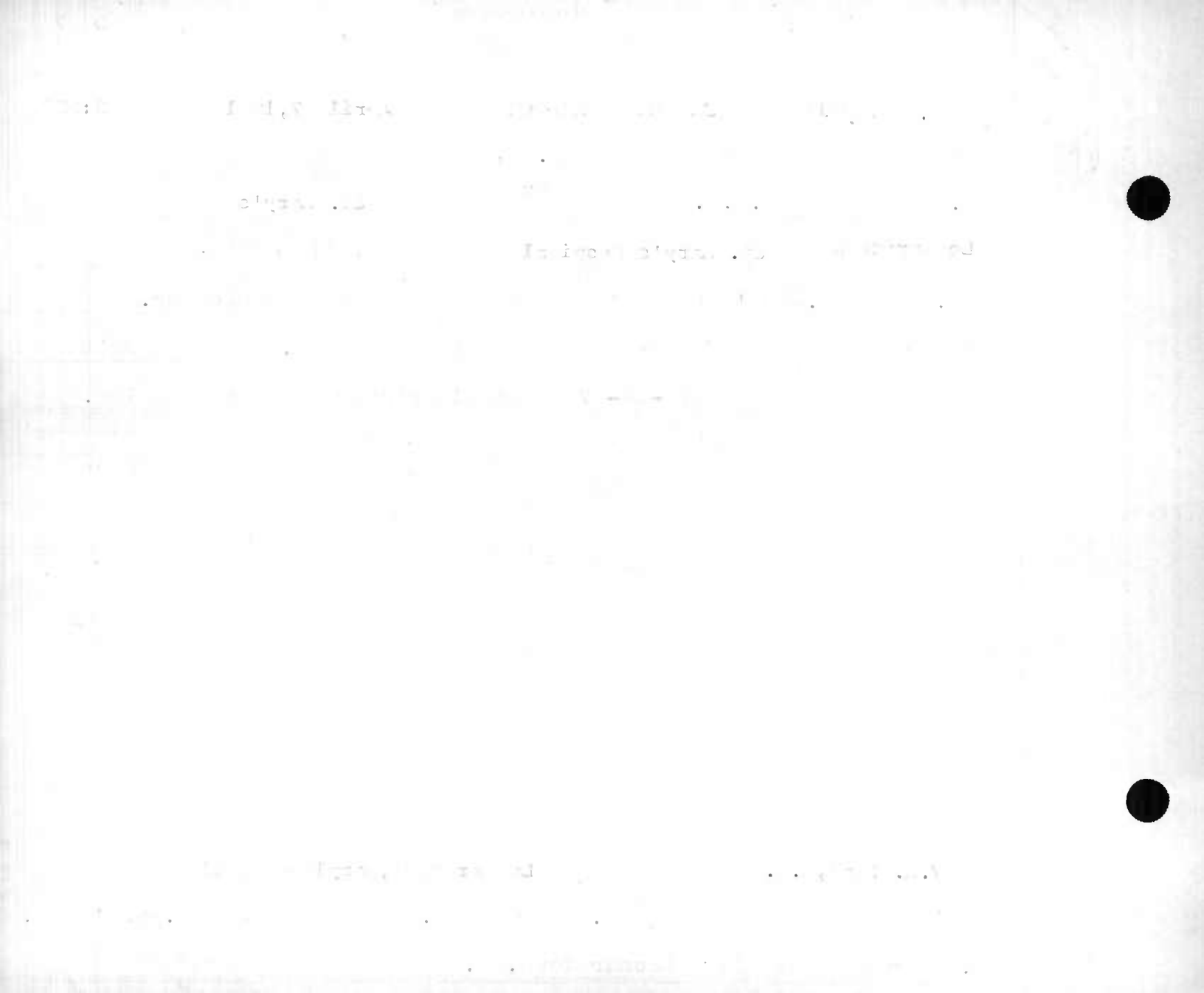


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked ar item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 1 3 5 9	
1 - FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ARTHUR JEROME MADDOX			2a. DATE OF DEATH April 7, 1981		2b. HOUR 3:37 P.M.
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Aug. 7, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.	
10. CITY OR TOWN OF DEATH Leonardtwn	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Service		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. CITY OR TOWN St. Mary's Lexington		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Maddox			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie R. Smith		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 213-18-3706A		17. INFORMANT ADDRESS Joslin richardson Same as 13c.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH 2 metastases 1519 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Severe Coronary artery dis Hypertensive cardiovascular dis DUE TO, OR AS A CONSEQUENCE OF (c) Chronic renal insufficiency Uremia Cardiac arrest					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 Hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V.K. Shah, M.D.		22e. ADDRESS Leonardtwn, Maryland 20650			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/10/81		23c. NAME OF CEMETERY OR CREMATORY St. George Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Valley Lee St. Mary's Md.		23e. DATE REC'D. BY REGISTRAR APR 13 1981		23f. REGISTRAR'S SIGNATURE 	
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley		ADDRESS Leonardtwn, Md.			



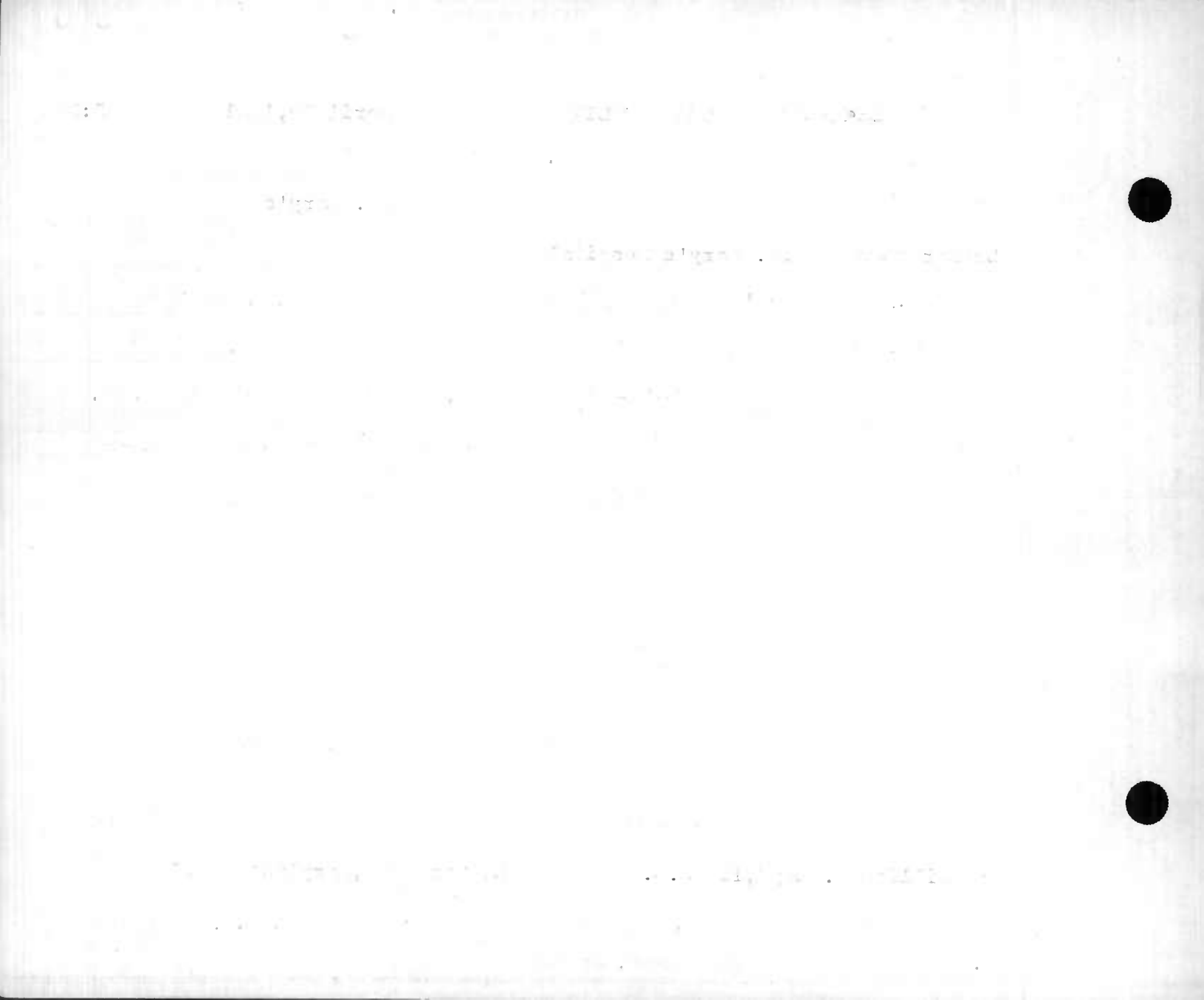
TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 1 1 3 6 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ALEXANDRA OLGA ORLIK			2a. DATE OF DEATH MONTH DAY YEAR April 20, 1981		2b. HOUR 05:34AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 27, 1904	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) Lodz, Poland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.		
10. CITY OR TOWN OF DEATH Leonardtwn	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY St Mary's	13c. CITY OR TOWN Great Mills	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Julian Kowalewski			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Slawinska		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR OATES) Army	17. INFORMANT ADDRESS Paul D. Kessler Great Mills, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic disease DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sec.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/19/81, 19 to 4/20/81, 19, that (I) (we) lost saw the deceased alive on 4/19/81, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE William D. Boyd, II		DEGREE M.D.		22c. DATE SIGNED 4/20/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William D. Boyd, II M.D.		22e. ADDRESS Leonardtwn, Maryland 20650			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE April 21, 1981	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN Suitland, P.G.	COUNTY STATE Maryland
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley		ADDRESS Leonardtwn, Maryland		25a. DATE REC'D. BY REGISTRAR APR 23 1981	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Item #1 Film 555 5/5/81 rc

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		Orlik		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
John						Orlick				4-12		1981									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		7d. HOUR	
male		white		Oct. 29, 1925		55 YRS.						4-12		1981						7:05	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH									
New York		USA										St. Mary's County									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Leonardtown		St. Mary's Hospital																			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
Maryland		St Mary's		Great Mills		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		G. D													
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																			
John		Olga																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS															
Yes						Paul D. Kessler		Great Mills, Maryland													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I DEATH WAS CAUSED BY:																					
IMMEDIATE CAUSE (a)																					
4292																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																					
(b)																					
DUE TO, OR AS A CONSEQUENCE OF																					
(c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?																	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
		P.M. 19																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION																	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED																	
Margarita A. Korell, M.D.		Assistant		4-13-81																	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION															
Cremation		Apr. 14, 1981		Cedar Hill		Suitland, P.G.															
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REC'D BY SIGNATURE															
W. Clarke Mattingley		Leonardtown, Maryland		APR 16 1981																	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM NELSON REICHARD						2a. DATE OF DEATH MONTH DAY YEAR APRIL 13, 1981				2b. HOUR 2:00 A.M.	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR APRIL 6, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S MD.					
10. CITY OR TOWN OF DEATH MECHANICSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RT. BOX 557 Richneck Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MACHINIST		12b. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE			
13a. STATE MARYLAND		13b. COUNTY ST. MARY'S		13c. CITY OR TOWN MECHANICSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RT. BOX 557		13f. STREET ADDRESS Richneck Road	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES REICHARD				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALVINA KEMMERER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) unknown				16b. SOCIAL SECURITY NO. 183-10-2102		17. INFORMANT ADDRESS James W. Reichard, P.O. Box 557, Mechanicsville, Md. 20659					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebrovascular disease</u> (c) <u>YPS.</u>										APPROPRIATELY ATTESTED 20659	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3-4-81</u> , 19 <u>81</u> , to <u>4-13-81</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>4/13</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>William Boyd</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/13/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM D. BOYD, 11 M.D.				22e. ADDRESS Leonardtowntown, Maryland 20650							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 4-16-81		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Rock York Penn.			
24. FUNERAL DIRECTOR NAME James J. Hartenstein				ADDRESS New Freedom, Pa.		25. DATE REC'D. BY REGISTRAR APR 20 1981		25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 1 1 3 6 3	
FOR STATE REGISTRAR				CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) JOHN ARTHUR REIS				2a. DATE OF DEATH MONTH DAY YEAR April 25, 1981				2b. HOUR 12:36 A.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 22, 1899		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Portugal		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.					
10. CITY OR TOWN OF DEATH Leonardtwn		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY St. Mary's		13c. CITY OR TOWN St. Inigoes		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Star Route Box 9			
14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL REIS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY VeADA							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 136-05-8046		17. INFORMANT ADDRESS A Eugenia Martin Reis Same as 13e.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis Shock 5901 DUE TO, OR AS A CONSEQUENCE OF: (b) Pyelonephritis (acute) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) _____ DUE TO, OR AS A CONSEQUENCE OF: (d) _____ (e) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 3/12 , 19 81 , to 4/25 , 19 81 , that (I) (we) last saw the deceased alive on 4/24 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE James C. Boyd, M.D.				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/25/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James C. Boyd, M.D.				22e. ADDRESS Leonardtwn, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/26/81		23c. NAME OF CEMETERY OR CREMATORY Charles Memorial Gdn. Leonardtown		23d. LOCATION CITY OR TOWN COUNTY STATE St. Mary's					
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley				ADDRESS Leonardtwn, Md.				25. DATE RECEIVED BY REGISTRAR APR 28 1981		25b. REGISTRAR'S SIGNATURE Robert A. Kelley Md.	

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. HOUR	
FIRST Myrtle		MIDDLE Hewitt		LAST Russell		2b. HOUR 10700 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 18, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Valley Lee, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		7c. DATE PRONOUNCED DEAD April 12, 1981	
10. CITY OR TOWN OF DEATH Leonardtwn		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. CITY OR TOWN St. Mary's		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS G.D.	
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Hewitt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Redman		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 295-12-8942 219-48-6137	
17. INFORMANT ADDRESS Lucy Mae Hanson		17. INFORMANT ADDRESS Valley Lee, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Artery Thrombosis</u> 4100 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <u>Myo Cardial infection</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>3 wk</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wk	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE William D. Boyd, M.D.		TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER		DATE SIGNED 4-13-81			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS Leonardtwn, Md.		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/14/81	
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley		ADDRESS Leonardtwn, Md.		23c. NAME OF CEMETERY OR CREMATORY St. George Cath. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Valley Lee, St. Mary's Md.	
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE APR 14 1981					



Handwritten signature or initials in the bottom left corner.

APR 14 1964

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (5))
15M 7/76

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11365	
1. DECEASED NAME (TYPE OR PRINT) Lester A. Schlup										2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 4-8-81 19 11:00 AM										2b. HOUR 11:00 AM	
1. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH Dec. 7, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD April 8, 1981		2d. HOUR 11:00 AM									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.									
10. CITY OR TOWN OF DEATH Leonardtwn				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Public Relations				12b. KIND OF BUSINESS OR INDUSTRY US. Government									
13a. STATE Maryland				13b. CITY OR TOWN St. Mary's		13c. CITY OR TOWN California		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. # 2, Box 219											
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Schlup					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Smith																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes					16b. SOCIAL SECURITY NO. WW 1 579-60-2216					17. INFORMANT Irene W. Schlup ADDRESS Rt. # 2, Box 219 California, Maryland											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 Years																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Diabetis Mellitus																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE W.D. Boyd				TITLE (SPECIFY) Dep.				MEDICAL EXAMINER				DATE SIGNED 4-9-81									
EXAMINER'S NAME (TYPE OR PRINT) William D. Boyd M.D.				ADDRESS Leonardtwn, Maryland																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 4-9-81		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Prince Georges Md.											
24. FUNERAL DIRECTOR NAME Brinsfield Funeral Home				ADDRESS Leonardtwn, Maryland				25a. DATE REC'D. BY REGISTRAR APR 15 1981				25b. REGISTRAR'S SIGNATURE [Signature]									

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APR 21 1964

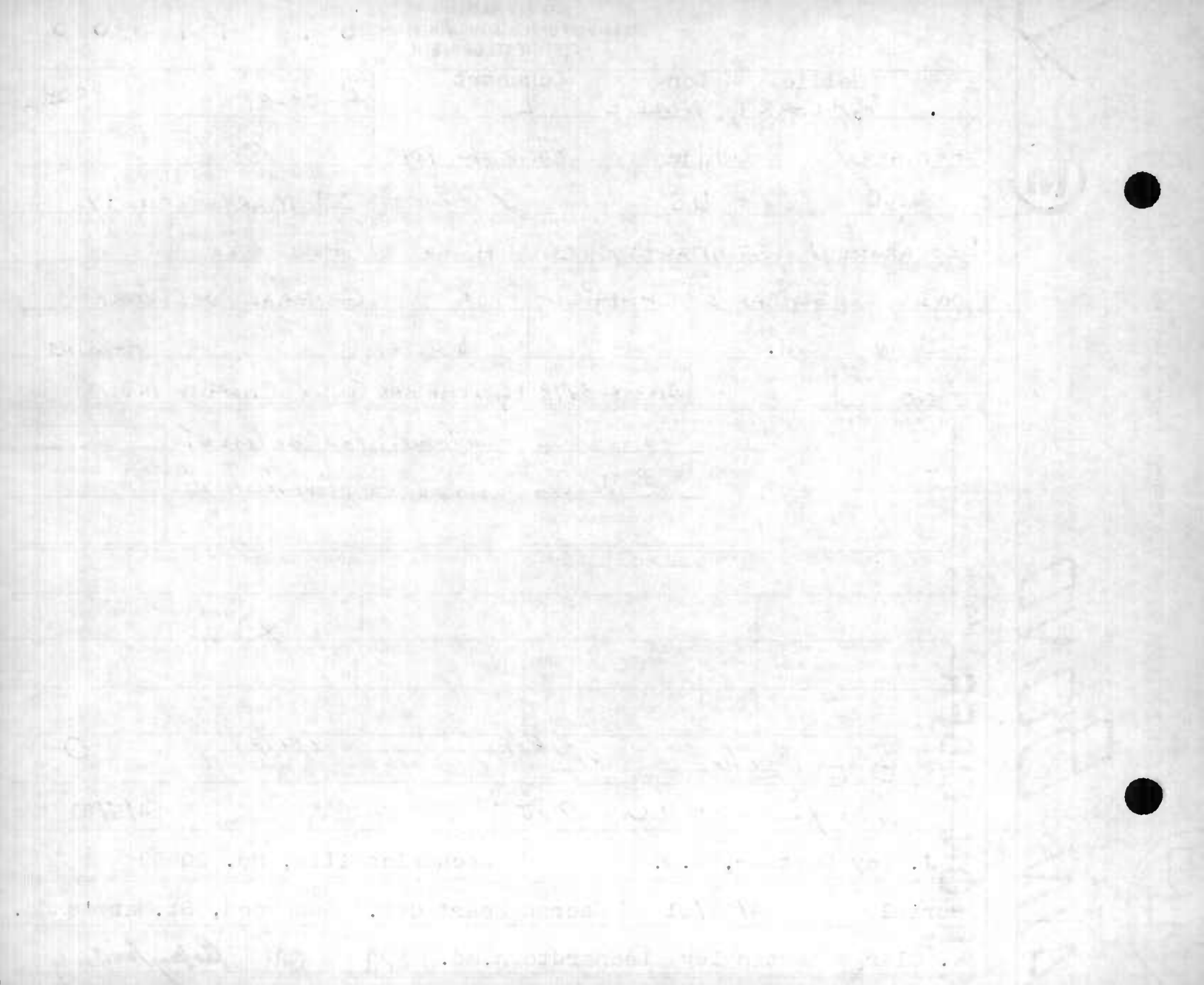
FOR
1 - STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Nellie Long Schuhart SCHUHART, NELLIE L		2a DATE OF DEATH MONTH DAY YEAR 4-09-81		2b HOUR 304 AM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 02-26-1893	
6a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		6b CITIZEN OF WHAT COUNTRY? U.S.		6c AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 88 YRS.	
7a CITY OR TOWN OF DEATH LEONARDTOWN		7b NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. MARY'S NURSING Home		7c BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S COUNTY MD.	
8 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD.		8b CITY OR TOWN ST. MARY'S		8c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9 FATHER'S NAME FIRST MIDDLE LAST JOHN H. LONG		9b MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mollie HARDING		9c STREET ADDRESS GENERAL DELIVERY	
10 WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		10b SOCIAL SECURITY NO. 215-38-3479		10c INFORMANT ADDRESS ELIZABETH ANN FOWLER, CHAPTICO MD.	
11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia - glomerular sclerosis</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascularis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
MEDICAL CERTIFICATION					
12a DATE OF OPERATION		12b CONDITION FOR WHICH OPERATION WAS PERFORMED		12c AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
12d ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		12e TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		12f HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 12b, PART 1 OR PART 2)	
12g INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		12h PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		12i LOCATION CITY OR TOWN COUNTY STATE	
12j I certify that (I) (this hospital) attended the deceased from <u>4/6/81</u> 19 <u>81</u> to <u>4/9/81</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>4/6/81</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I will read and sign this after death.					
12k SIGNATURE J. Roy Guyther, M.D.		12l DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		12m DATE SIGNED 4/9/81	
12n PHYSICIAN'S NAME (TYPE OR PRINT) J. Roy Guyther, M.D.		12o ADDRESS Mechanicsville, Md. 20659			
13a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		13b DATE 4/11/81		13c NAME OF CEMETERY OR CREMATORY Sacred Heart Cem.	
13d LOCATION CITY OR TOWN COUNTY STATE Bushwood, St. Mary's Md.		13e DATE REC'D. BY REGISTRAR APR 13 1981		13f REGISTRAR'S SIGNATURE Rafaela M. Brady	
14 FUNERAL DIRECTOR NAME W. Clarke Mattingley		14b ADDRESS Leonardtowntown, Md.		14c DATE REC'D. BY REGISTRAR APR 13 1981	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Mary Elizabeth Thompson			2a. DATE OF DEATH MONTH DAY YEAR April 12, 1981			2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 9, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.	
10. CITY OR TOWN OF DEATH Morganza		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Md.		13b. COUNTY St. Mary's		13c. CITY OR TOWN Morganza		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Quincy Cusic		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Graves					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-44-3402 220-16-4205B		17. INFORMANT ADDRESS Ada Russell Morganza, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Probable Cerebrovascular Accident</u> 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebrovascular Disease</u> (c) <u>yes</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2-26-81</u> , 19 <u>81</u> , to <u>4-8</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>4-8</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>William D. Boyd, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4/13/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William D. Boyd, M.D.				22e. ADDRESS Leonardtwn, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/14/81		23c. NAME OF CEMETERY OR CREMATORY St. Joseph Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Morganza St. Mary's Md.	
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley				ADDRESS Leonardtwn, Md.		25a. DATE REC'D. BY REGISTRAR APR 16 1981	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1801 A 1201

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

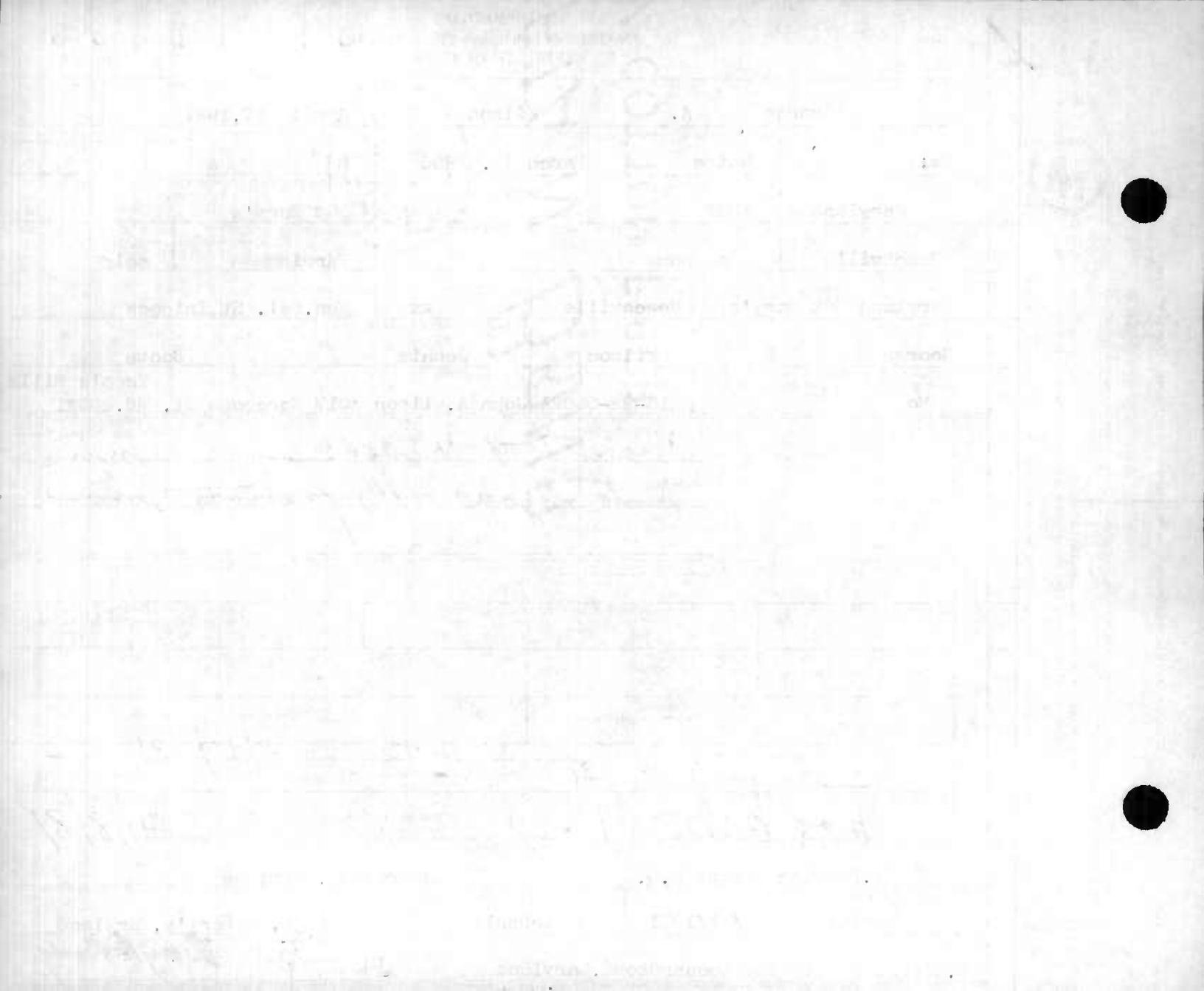
1. DECEASED NAME (TYPE OR PRINT) George A. Wilson			2a. DATE OF DEATH MONTH DAY YEAR April 17, 1981			2b. HOUR M AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 11, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 85		7. IF UNDER 1 YEAR MONTHS DAYS YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St Mary's MD.				
10. CITY OR TOWN OF DEATH Beachville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) at home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farming		12b. KIND OF BUSINESS OR INDUSTRY self		
13a. STATE Maryland			13b. COUNTY St Mary's		13c. CITY OR TOWN Beachville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Gen. Del. St Inigoes	
14. FATHER'S NAME FIRST MIDDLE LAST George R Wilson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie Booth			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				
16b. SOCIAL SECURITY NO. 213-22-0602A			17. INFORMANT ADDRESS Temple Hills			17. INFORMANT ADDRESS John A. Wilson 4017 Norceoss St. Md. 20031				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Collapse 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) min								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH min		
PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 4-14-81 to 4/17-81 , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on 4-14-81 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> saw the body after death.										
22b. SIGNATURE J. Patrick Jarboe M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/18/81		
22d. PHYSICIAN'S NAME (TYPE PRINT) J. Patrick Jarboe M.D.			22e. ADDRESS Leonardtwn, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/21/1981		23c. NAME OF CEMETERY OR CREMATORY St Michaels		23d. LOCATION CITY OR TOWN COUNTY STATE Ridge, St Mary's, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS W. Clarke Mattingley Leonardtown, Maryland			25a. DATE REC'D. BY REGISTRAR APR 21 1981			25b. REGISTRAR'S SIGNATURE John A. Wilson				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR TO EXECUTE THE CERTIFICATE. WRITING TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3 FOR VOUCHER. RETURN PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER. RETURN PAGES 6 AND 7 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. HENRIETTA STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										11369	
FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT PATRICK WRIGHT										2a. DATE KNOWN OF DEATH ESTI- MATED 18 19 81 0017 M	
3. SEX Male 4. RACE Caucasian 5. DATE OF BIRTH MONTH DAY YEAR March 28 1919 62 YRS. 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 7c. DATE PRONOUNCED DEAD April 19 1981 0017 M										2b. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.	
10. CITY OR TOWN OF DEATH Leonardtown 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. Navy(Retired) 12b. KIND OF BUSINESS OR INDUSTRY											
13a. STATE Maryland 13b. COUNTY St. Mary's 13c. CITY OR TOWN Hollywood 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS Rt. # 3, Box 385											
14. FATHER'S NAME FIRST MIDDLE LAST Martin Wright 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Hoffman											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes 16b. SOCIAL SECURITY NO. WW 11 122-07-2524 17. INFORMANT ADDRESS Mary M. Wright, Hollywood, Maryland											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia Arrhythmia 4149 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immd. 5 yrs											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE [Signature] M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 4-20-81											
EXAMINER'S NAME (TYPE OR PRINT) William D. Boyd M.D. ADDRESS Leonardtown, Maryland											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 4-22-81 23c. NAME OF CEMETERY OR CREMATORY St. Johns 23d. LOCATION CITY OR TOWN COUNTY STATE Hollywood, St. Mary's Md.											
24. FUNERAL DIRECTOR NAME ADDRESS Brinsfield Funeral Home Leonardtown, Md. 25a. DATE REC'D. BY REGISTRAR APR 22 1981 25b. REGISTRAR'S SIGNATURE [Signature]											

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